

**Maryland Health Quality and Cost Council**  
**Monday, September 26, 2011**  
**9:30 a.m. – 12:00 p.m.**  
**UMBC Technology Center**

MEETING NOTES

Members present: Sec. Joshua Sharfstein (Vice Chair), James Chesley, Lisa Cooper, Richard “Chip” Davis, Barbara Epke, Roger Merrill, Peggy O’Kane, Marcos Pesquera, Frances Phillips, E. Albert Reece, Jon Shematek, Kathy White, Christine Wray, and via telephone, Lt. Governor Brown (Chair), and Jill Berger.

Members absent: Debbie Chang.

Staff: Laura Herrera, Frances Phillips, Karen Rezabek, Grace Zaczek, and via telephone: Ben Stutz.

**Meeting Materials**

All meeting materials are available at Council’s website:  
<http://dhmh.maryland.gov/mhqcc/meetings.html>

**Welcome and Approval of Minutes**

The meeting was called to order at 9:40 with opening remarks from Secretary Joshua Sharfstein. The Secretary welcomed the members and thanked them for all their efforts in the Council’s workgroups. The Secretary thanked Grace Zaczek for serving as Acting Director for the Council in Nicole Stallings’ absence, and announced that Nicole is the proud mother of a new baby boy. The Secretary introduced Laura Herrera, M.D., a family physician who has joined DHMH as the Department’s Chief Medical Officer, and who previously served as Acting Deputy Chief Officer for Patient Care Services for the U.S. Department of Veterans Affairs where she was responsible for 152 acute care hospitals and 1,000 outpatient centers, and as Deputy Commissioner for the Baltimore City Health Department. The Secretary then asked the Council members to introduce themselves. Following introductions the June 10, 2011 meeting minutes were approved.

**UPDATE PRESENTATIONS**

**Federal Health Care Reform and Maryland Implementation – Secretary Sharfstein**

Secretary Sharfstein provided an overview of progress on health reform implementation. Ms. Carolyn Quattrocker has been appointed as Director for the Health Reform Coordinating Council (MHRCC) which will oversee implementation of health care reform activities across the state. Secretary Sharfstein explained that the Federal Centers for Medicare and Medicaid Services (CMS) has determined that Maryland Insurance Administration (MIA)’s process for reviewing requested health insurance rate increases in the individual and small group markets conforms to the federal

Affordable Care Act criteria. Therefore CMS will accept MIA's decisions on rate increases rather than conducting its own review. He noted that the Maryland Department of Labor, Licensing and Regulation in its role on MHRCC will address workforce issues related to health reform.

The Secretary discussed the State Health Improvement Plan (SHIP), spearheaded by Dr. Madeleine Shea that consists of 39 measures where improving health status in Maryland is feasible. Twenty four of the measures address critical ethnic and racial disparities. The measures are designed for accountability through actions taken at a local level in communities around the state. Each jurisdiction has formed a coalition to create a local health improvement plan, using start up funds provided by the Maryland Hospital Association to its member hospitals.

The Department has consciously engaged public comment in developing the State plan with listening sessions held around Maryland, and hundreds of comments received from the public. Deputy Secretary Fran Phillips added that the next session is scheduled for September 27<sup>th</sup> in southern Maryland, and will include representatives from local health departments, Federally Qualified Health Centers, and school superintendents. Secretary Sharfstein commented that the plan is an opportunity for bridging the gap between Public Health and the medical system. At the local level it can engage hospitals, health departments and the medical community with concrete tools for improving the health status of all Maryland residents. Secretary Sharfstein gave Council members the SHIP website:

<http://dhmh.maryland.gov/ship/index.html>

The Secretary reported that the Maryland Health Benefit Exchange Board, which he chairs, has hired Rebecca Pearce as its executive director. The nine-member board has formed four advisory committees and chosen vendors to carry out six projects related to improving the availability of health insurance coverage for the small group and individual markets. Roger Merrill suggested that an issue for the exchange is the cost per person for a business to obtain insurance, and that it costs companies \$2,000 person to cover employees. Dr. Sharfstein said the exchange has engaged the vendor who worked with the Massachusetts exchange to examine the issue in Maryland. The Exchange's work will build on the small business market. Christine Wray suggested looking at long term Medicaid issues.

It was noted that Federal reform is limiting states' ability to tax providers, and the Secretary reported that the Medicaid Advisory Committee is examining strategies to limit Medicaid costs; cost control is knocking on everyone's door, and controlling costs is everyone's responsibility with controls that help rather than hurt patients. Dr. Merrill commented that the Council exists to improve care and decrease health care costs. Further discussion included the opportunity to bridge the gap between Public Health and medical systems. At the local level this encompasses hospitals, local health departments and the medical community.

Ben Stutz noted that the Lieutenant Governor is encouraged with the progress made by the Health Reform Coordinating council, and looks forward to seeing the work of the Maryland Health benefit Exchange Board. Secretary Sharfstein gave the Council the exchange's website:

<http://dhmh.maryland.gov/healthreform/exchange/index.html>

### **Health Disparities Workgroup – E. Albert Reece, University of Maryland School of Medicine**

Dr. Reece's presentation is available on the Council's website. Dr. Reece listed the Workgroup members for the Council and noted that these individuals were not appointed, but identified by the Lieutenant Governor and the Secretary because of their interest in addressing disparities. Starting with a blank slate, in three productive meetings, the group will not solve all problems

related to disparities, but will focus on areas where a large impact is possible. The workgroup expects to offer strategies that are reasonable approaches with a reasonable timeline to realize good outcomes. Examining regional and national reports, the group used published, well established data to identify three chronic conditions with excess risk in the minority community that would benefit from efforts to reduce disparities: asthma, diabetes and hypertension. Dr. Merrill said that better outcomes are achieved with non-invasive care. Dr. Reece agreed and stated that minorities need more hospital admissions that they're getting for these conditions.

The workgroup is considering a "Health Empowerment Zone" (HEZ) is a first strategy to reduce disparities. The zone would be a designated area eligible to receive additional resources and incentives for providers to locate and serve underserved individuals, including minorities. Residents in these zones would be empowered to take more responsibility for and have more control over their health care. The workgroup has had a robust discussion highlighting incentives, and required interventions and incentives, including those for reimbursement to improve quality of care in the HEZ.

The second strategy will be a "Maryland Community Health Prize." Different from a grant which is given for an idea, the prize would be awarded for results. The goal is to encourage people to be creative in identifying effective approaches to reducing disparities that could be expanded to cover the entire state.

Secretary Sharfstein stated these are very "meaty" ideas the workgroup is developing, and the Department is committed to helping talk about how to integrate workgroup recommendations into existing initiatives. He stated that the prize may fit into the State Health Improvement Plan, and that he found the HEZ to be an intriguing concept.

Barbara Epke commented that the workgroup's efforts are excellent. They address hospital's concerns about admissions and re-admissions for the same problem. Ms. Epke stated that there is a need for interim outcomes that focus on prevention even more than on admissions. Dr. Merrill added that the strategies fit with the Wellness and Prevention Workgroup's activities, as the Disparities group's recommendations address community-based health and wellness. Ms. Peggy O'Kane suggested setting specific targets for admission reduction. She cited a New York State Medicaid study which showed that where people received care influenced hospital admissions. There were more admissions from hospital outpatient clinics in the study.

### **Maryland Multipayer PCMH Program - Ben Steffen, Maryland Health Care Commission**

Secretary Sharfstein told the Council that Ben Steffen's presentation would be a bit different than usual as it would include actual providers giving their perspective on the Patient Centered Medical Home (PCMH) program. Ben Steffen began the presentation (available on the MHQCC website) with an update, commenting that participating practices in the Maryland Multi-Payer PCMH Program (MMPP) represent diverse service types and locations, which is ideal to serve a broad base of Maryland patients. He announced that the Maryland Health Care Commission has awarded a contract to IMPACT with Johns Hopkins Bloomberg School of Public Health and the University of Maryland's School of Pharmacy as subcontractors to evaluate the PCMH program.

Mr. Steffen then introduced Dr. Howard Haft of Shah Associates, a primary care practice in Southern Maryland. Dr. Haft said when he taught Masters of Business Administration students at Georgetown, the data on health care costs never went in the right direction. He commented paraphrasing Charles Dickens, “This is the best of times; this is the worst of times.” Dr. Haft described how participation in the PCMH program caused his practice to really look at how they did business and what the needs were of their population. Shah Associates grew over time to 120 physicians in 5 sites serving 120,000 patients, including 16,000 diabetics, 3,000 or 4,000 of who are poorly controlled. The practice has brought on a registered diabetes educator and an endocrinologist, and has begun working with local hospitals to be notified when their patients are admitted. This has helped focus on follow up care and reduced re-admissions. The practice has had an Electronic Medical Record (EMR) since 1993, and is now pushing towards meaningful use.

Dr. Haft said the challenge is to conduct a “value-based” practice versus a volume-based one, and sustainability for the PCMH concept after the current program ends. Dr. Haft concluded that it will be necessary to see if the system really stays at value after the funding ends.

Dr. Kim Johnston of Johnston Family Medicine in Carroll County told the Council that she has spent her entire career in Maryland with 11 years in practice. During these 11 years when she has had an EMR, she is still not using it to full capacity. Dr. Johnston also heads Carroll Hospital Group which faces different challenges from her private practice. Before joining the PCMH program, Dr. Johnston found herself running from one major issue to the next, with no satisfaction, feeling patients were receiving less than good medical care, and physicians in the practice were unhappy.

Dr. Johnston sees PCMH as a huge opportunity to increase patient and physician satisfaction and to deliver better care. She noted that PCMH is not new, but it just makes sense. She said she is pleased that both the hospital’s program and her practice were chosen to participate in the program.

Dr. Richard Fornadel of Aetna presented the payor’s view of PCMH, that it is needed to address the shortage of physicians, and will have expected benefits for consumers, particularly better ambulatory care. Dr. Fornadel stated that improved health and wellness will result in more savings on health care costs. Dr. Fornadel told the Council that he sits on the Patient Centered Primary Care Collaborative’s Executive Committee.

Dr. Fornadel said challenges with PCMH include the large amount of resources needed to collect and analyze data, patient attribution, consolidation of the provider market, and how PCMH will play into the Accountable Care Organization. Peggy O’Kane addressed the intersection of high insurance deductibles with PCMH. Patients with these plans are not going to primary care. Dr. Haft agreed that this is keeping people from getting primary care. Dr. Johnston said that 30 to 40 percent of her patients have high deductible plans.

Dr. Kathleen White asked if Aetna would have seen a reduction in Emergency Room visits and hospital admissions anyway during the first year of its PCMH program due to high deductible

plans. Dr. Fornadel said that compared to the market in general, PCMH practices are doing a better job of keeping patients out of the ER and the hospital.

Ben Steffen ended the presentation by recognizing Ms. Epke and Dr. White's service on the PCMH Workgroup, which Dr. White chaired.

**Healthiest Maryland Businesses – Roger Merrill, Perdue Farms, Inc., Member, Wellness and Prevention Workgroup**

The workgroup's presentation was deferred until the December, 2011 meeting when more complete data will be available.

**Wellness and Prevention Workgroup – Jon Shematek, CareFirst**

Dr. Jon Shematek's presentation is available on the Council's website. Dr. Shematek recapped that "RIPE" is used to evaluate population health strategies – Reach, Impact, Partnerships and Ease of Execution. As the individual effort needed for a particular activity increases, the effect on population health decreases. He reported that workgroup staff interviewed three other agencies while assessing national nutrition and tobacco cessation policy program toolkits. Other jurisdictions have found that it takes 18-24 months to develop policies. In Maryland, 47 hospitals and 11 colleges have smoke-free campuses.

Dr. Shematek then asked Ms. Frances Phillips, Deputy Secretary for Public Health to further discuss the workgroup's recommendation on developing health promotion policies in State-run facilities and campuses. Ms. Phillips discussed a detailed, results-oriented memo written for the Council which recommends that the State create a taskforce to design and implement statewide wellness policies. Ms. Phillips explained that the State has 140,000 covered lives in its employee health insurance programs, and told the Council that health promotion efforts wouldn't be budget-neutral; therefore it has been essential to have the Department of Budget and Management on the taskforce.

Secretary Sharfstein recused himself from voting on the recommendation since it would impact the Department. Dr. Merrill said that Perdue is moving towards a tobacco free environment. Ms. Jill Berger stated that Marriott has had no complaints about reducing transfats in the food it serves. Peggy O'Kane wished the workgroup "Godspeed" in its efforts. Ms. O'Kane made a motion, seconded by Dr. White, and approved unanimously, with Secretary Sharfstein not voting, to accept the taskforce's memo and its recommendations.

**Telemedicine Task Force – Robert Bass, Maryland Institute for Emergency Medical Services Systems**

Dr. Bass' presentation is available on the Council's website. Dr. Bass explained that the last Telemedicine Taskforce focused on stroke care. The Council recognized the need to expand the scope of telemedicine activities in Maryland beyond stroke care, forming the current taskforce. Dr. Bass described the activities of the taskforce's three advisory groups – Clinical, Technology

Solutions and Standards, and Financial and Business Model. The Clinical group heard a presentation from Dr. Karen Reuban of the University of Virginia that recounted Virginia's experience that the key drivers for the success of telemedicine were state level leadership and reimbursement. The group heard David Finney, a consultant working with CRISP (Chesapeake Regional Information System for our Patients), Maryland's Health Information Exchange discuss the exchange's interface with telemedicine. Dr. Claudia Baquet spoke on the University of Maryland's experience with telemedicine, and Dr. David Winn described CareFirst's changes in reimbursement in the Mid-Atlantic region. Ms. Virginia Rowthorn from the University of Maryland presented her white paper on the legal issues surrounding telemedicine.

The Technology Solutions and Standards Advisory Group, chaired by Dr. David Sharp discussed the functionalities of the current technology to implement telemedicine, and the standards supporting interoperability from other industries. The workgroup drafted principles for interoperability standards:

- Acute care hospitals should support interoperable telemedicine networks using Internet transport protocols
- The standards should define a minimum technology to be in place
- Information related to telemedicine consults should be able to be imported into an electronic health record
- An interoperable telemedicine infrastructure should support resource management or directory services
- An interoperable telemedicine infrastructure should be affordable, scalable, and support open standards.

Ben Steffen chaired the Financial and Business Model Advisory Group that examined the reimbursement experiences of early adopters in other states, and Medicare's reimbursement for telemedicine. The advisory group hopes to provide recommendations on:

- Types of services (CPT codes) to covered,
- Approaches to funding the needed infrastructure,
- Scope of coverage for telemedicine,
- Carrier and practice business and operating rule changes that need to occur, and
- Approaches to support rapid diffusion of telemedicine including provider and patient education.

Secretary Sharfstein said that how to appropriately regulate telemedicine is a continuing issue, and Ms. Nancy Grimm, Director of the Department's Office of Health Care Quality will work with the taskforce to address regulatory concerns. Dr. Bass commented that the State has a key role in the development of telemedicine and in fostering the concept for Marylanders, as it addresses the State's responsibility for the health care safety net.

Dr. Bass responded to Peggy O'Kane's question, stating that telemedicine can include home monitoring, and that Dr. Bass felt telemedicine has an intersection with Dean Reece's Health Disparities efforts.

**Evidence Based Medicine Workgroup – Richard 'Chip' Davis, Johns Hopkins Medicine**

Dr. Davis, whose presentation is available on the Council's website, told the Council he had just returned from Kuala Lumpur, where the largest franchise is "KFC." Dr. Davis reported that the Blood Wastage Collaborative in just 20 months' existence has saved 1,034 units of platelets and 629 units of plasma for a total of 1,663 units and \$558,833. In April, 2011, 35 of 44 hospitals submitted data for an 80% participation rate. Dr. Davis offered "kudos" to the American Red Cross for looking to take Maryland's program nationwide. Dr. Davis said the best practices learned as the collaborative developed will go forward, the data reporting will not continue. Collaborative members are planning to define next steps for the standardization of clinical protocols.

Dr. Davis reported that Dr. Cliff Mitchell, Liaison between DHMH and Maryland Department of the Environment, is convening an advisory group this fall to serve as a collaborative for hospitals who want to decrease their "red bag trash." In addition, he will be revising regulations, using the group's input to update the Maryland state requirements for regulated medical waste.

Dr. Davis explained that the Hospital Hand Hygiene Collaborative is in transition at the Maryland Patient Safety Center (MPSC). Dr. Davis said he had a good discussion with Carmela Coyle, CEO for the Maryland Hospital Association and the MPSC. The goal of hand hygiene activities is to positively impact Health Acquired Infections (HAI) over the long term. There is a need to clarify the metrics to be collected, and to send standardized reports, especially to hospital CEOs on their institution's performance in a timelier manner. There is ongoing discussion on the level of transparency in reporting data. Some "best practices" hospitals have agreed to have their data identified, with full transparency to be addressed in the future.

Ms. Barbara Epke recommended trying to engage additional hospitals in the collaborative. Dr. Davis said there is a need to engage them at the CEO level, and that Secretary Sharfstein wrote to non-participating hospitals to encourage their participation. The Secretary commented that the Workgroup still is engaged, with a need for specific metric definitions and clarity on data from hospitals. The Secretary saw the need to link Hand Hygiene data to HAI.

Dean Reece asked about a correlation between Hand Hygiene activities and HAIs. Dr. Davis reported that Johns Hopkins Hospital has seen a 43% reduction in VRE.

Dr. Davis said the next steps for the workgroup were to consider the Pre-39 week gestation elective delivery project being handled at HSCRC, with hospital rate-adjustment being implemented in the near future, and the incorporation of tobacco cessation treatment into inpatient setting and discharge planning for smoking patients.

## **ACTION ITEMS**

## **GUEST PRESENTATION**

**Academic Detailing** - Steven F. Farrell, National Resource Center for Academic Detailing

Mr. Steven Farrell, whose presentation is available on the Council's website, described "Academic Detailing" which attempts to meld the communication skills of the pharmaceutical manufacturing industry with those of medical schools' faculties as trusted sources of clinical information. Mr. Farrell said the goal is to bring the best available evidence into clinical practices as the basis for clinical decisions that are efficacious, safe and cost-effective. The stress is on efficacy as the first priority. He explained that medical school faculty and practitioners independently develop information based on up-to-date evidence about comparative efficacy, safety, and cost-effectiveness of commonly used therapies. Physicians, nurses and pharmacists then provide this information to community physicians in their own offices. With 17 new papers coming out each day, academic detailing is an efficient way for community providers to keep up with new findings.

Mr. Ferrell reported that a United Kingdom study showed a dramatic effect of academic detailing on medication prescribing, but only if academic detailing is done well. There are programs in eight states and the District of Columbia, and AHRQ is funding a new effort. In New York State, Medicaid funds 12 people to provide academic detailing, and Australia has a national program.

Mr. Ferrell discussed the scale of programs across the country from temporary to address a specific issue, to long term efforts with a wide range of topics. Mr. Ferrell explained that the National Resource Center for Academic Detailing works on measuring detailing programs' effectiveness. Secretary Sharfstein thanked Mr. Ferrell for his presentation, and noted there are programs in Maryland working already with the Center. Dr. Lisa Cooper asked about academic detailing's long term effectiveness and the need for refresher visits. Mr. Ferrell noted that the first visit to a provider is the most important.

Dr. Merrill commented that this is a great concept. Mr. Marcos Pesquera stated that it definitely changes prescribing patterns. Mr. Ferrell said that it has hospitals looking at changing standards of care. Dr. Shematek responded to the Secretary's question about private payors doing academic detailing, that no, but payors' pharmacists engage providers on their prescribing patterns. Dr. Cooper asked if there had been any examination of academic detailing's cost effectiveness. Mr. Ferrell said there is a difference between the spots of where practice is, and where it should be. Dr. Sharfstein commented that if a project is defined specifically enough, its outcomes can be measured.

## **NEXT STEPS**

There was discussion about high cost deductible health plans. People are choosing these plans for the low premiums, then not getting needed primary and preventive care. Dr. James Chesley asked that the Council look at the issue. Ms. Peggy O'Kane added that there is a need for value based insurance design and that Oregon is doing a lot on the issue. The Secretary said this is a topic for further discussion.

Secretary Sharfstein reminded the Council that the next meeting of the Council is December 16, 2011 from 9:30 AM to 12 noon. The meeting then adjourned at 11:57 AM.